HOME HEALTH CERTIFICATION AND PLAN OF CARE

Order ID 115022121

Patient Details

Patient's HI Claim No.	Start of Care Date	Certification Period	Medical Record No.	Provider No.
8JG5MT5NA64	09/15/2026	09/15/2026 - 11/13/2026	30139	217058

Patient's Name and Address	Gender	Date of Birth	Phone Number
Denise Carter Causion 2705 Overland Ave BALTIMORE, MD 21214	Female	12/17/1955	443-839-2921
	Email		Primary Language: English

Clinical Profile

Provider's Name	Address	Phone Number
HomeCentris Healthcare LLC	10 Crossroads Drive, Suite 102 Owings Mills, MD 21117	410-321-8448
NPI 1487113239		**Fax Number** 410-559-3002

Clinical Condition Requiring Homecare:

Home health skilled nursing, physical therapy, and occupational therapy assessments were completed for a 70-year-old female recently discharged from a skilled nursing facility following a fall in the bathroom resulting in a left displaced humeral neck fracture. Her medical history is significant for insulin-dependent type 2 diabetes mellitus, multiple fractures, atherosclerotic heart disease, hypertension, hyperlipidemia, GERD, edema, non-Hodgkin lymphoma, and right-sided hemiplegia secondary to CVA (02/25). The patient is alert and oriented 3, lives with her husband in a single-family home with six steps and a railing to enter, and has a bedroom and bathroom on the first floor. Vital signs are stable, and skin assessment revealed no current skin issues. Medication reconciliation was completed, and education was provided regarding medication management, insulin administration, blood glucose monitoring, recognition and management of hypo- and hyperglycemia, fall prevention, safe use of an assistive device, edema management, and skin integrity. The patient currently ambulates approximately 30 feet on indoor surfaces without an assistive device under supervision and occasionally reaches for environmental support. She requires supervision and verbal cues for bed mobility and transfers to the bed, chair, and toilet, particularly to maintain left upper-extremity non-weight-bearing precautions. She demonstrates decreased standing balance, standing tolerance, bilateral upper-extremity strength, and overall activity tolerance, resulting in reduced independence with self-care, functional transfers, and ambulation. Tinetti score is 15/28, indicating increased fall risk, and the patient is considered homebound due to the considerable effort and assistance required to leave the home. She tolerated therapeutic exercises including hip flexion, bridging, trunk rotation, straight-leg raises, hip abduction, knee extension, and ankle pumps. Continued skilled nursing, PT, and OT services are indicated for disease and medication management, strengthening, balance and mobility training, ADL retraining, safety education, fall prevention, and progression

Physician Statement on Homebound Status:

Due to diagnosis of Type 2 diabetes mellitus with hyperglycemia, unspecified, the patient is experiencing decreased endurance and mobility, increasing the likelihood of falls. To safely leave their home, the patient needs assistance from another person and an assistive mobility device

toward prior level of function. The patient is also advised to follow up with orthopedic physician Dr. Shiu regarding the left shoulder fracture to determine whether weight-bearing restrictions can be advanced.<o:p></o:p>

Date of Order<o:p></o:p>
09/15/2026<o:p></o:p>
Physician Face-to-Face Date:
09/04/2026<o:p></o:p>
Clinical Condition Requiring Home Care per Certifying Physician: sn-disease management pt-eval & treat ot-eval & treat dx: Type 2 diabetes mellitus with hyperglycemia<o:p></o:p>
Homebound Status per Certifying Physician: patient requires another person or medical equipment such as crutches, a walker, or a wheelchair to leave home<o:p></o:p>

1 - SOC - SN Notes: <o:p></o:p>
PT Eval Notes:<o:p></o:p>
OT Eval Notes:<o:p></o:p>
Physician: Akkad, Ayman

ICD-10 CM Principal Diagnosis: E11.65. Type 2 diabetes mellitus with hyperglycemia

Other Pertinent Diagnoses

ICD-10 CM	Description	Medications
D50.9	Iron deficiency anemia unspecified	ACETAMINOPHEN 325 MG Tablet / GIve 2 tablet by mouth every 6 hours as needed for Mild Pain/Moderate Pain Not to exceed 3 grams Acetaminophen in 24 hours. ASPIRIN Give 81 MG Tablet by mouth one time a day for PAD Prophylaxis ATENOLOL 25 MG Tablet / Give 2 tablet by mouth two times a day for Hypertension Atorvastatin Calcium - Atorvastatin Calcium 80 MG / 1 Tablet by mouth in the evening for High Cholesterol CALCIUM CARBONATE 600 MG / 1 Tablet by mouth in the morning for Heart Burn CHOLECALCIFEROL Give 2000 unit Tablet by mouth once a day for supplement Ferrous Sulfate - Ferrous Sulfate: Folic Acid 325 (65 Fe) MG / 1 Tablet by mouth one time a day for iron deficiency anemia GABAPENTIN 300 MG / 1 Capsule by mouth four times a day for Neuropathy Hydralazine Hydrochloride - Hydralazine Hydrochloride 25 MG / 1 Tablet by mouth three times a day for Hypertension HYDROCHLOROTHIAZIDE 25 MG / 1 Tablet by mouth in the morning for HTN Hold for SBP <100 HR <60 Insulin Lispro (1 Unit Dial) Solution Pen-injector 100 UNIT/ML subcutaneous after meal Inject as per sliding scale: if 200 - 250 = 2 units; 251 - 300 = 4; 301 - 350 = 6; 351 - 400 = 8 above 400 or below 70 notify provider. For DM Metformin Hcl - Metformin Hydrochloride Give 750 MG Tablet by mouth two times a day for Diabetes Pantoprazole Sodium - Pantoprazole Sodium Delayed Release 40 MG / 1 Tablet by mouth one time a day for GERD LANTUS Subcutaneous Solution 100 UNT/ML / Inject 65 unit subcutaneously at bedtime Inject 65units at bedtime for Insulin dependant diabetes Insulin Glargine-yfgn Solution Pen-injector 100 UNIT/ML / Inject 50 unit subcutaneous in the morning Inject 50units every morning for diabetes management
D50.9	Iron deficiency anemia unspecified	
M80.022D	Age-rel osteopor w crnt path fx l humer 7thD	
I69.351	Hemiplga following cerebral infrc aff right dominant side	
E11.51	Type 2 diabetes w diabetic peripheral angiopath w/o gangrene	
I11.0	Hypertensive heart disease with heart failure	
I50.32	Chronic diastolic (congestive) heart failure	
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy	
I25.10	Athscl heart disease of native coronary artery w/o ang pctrs	
E78.5	Hyperlipidemia unspecified	
K21.9	Gastro-esophageal reflux disease without esophagitis	
E55.9	Vitamin D deficiency unspecified	
Z79.84	Long term (current) use of oral hypoglycemic drugs	
Z79.4	Long term (current) use of insulin	
Z79.82	Long term (current) use of aspirin	
Z87.891	Personal history of nicotine dependence	
Z85.72	Personal history of non-Hodgkin lymphomas	
Z91.81	History of falling	

Prognosis
good

Mental and Psychosocial Status
COGNITION: 0. Alert/ oriented, able to focus and shift attention, comprehends and recalls task directions independently., ANXIETY: 0. Never, SOCIAL ISOLATION: 0. Never, BEHAVIORAL ISSUES: 7. None of the above behaviors demonstrated, HISTORY OF DEPRESSION: Yes

Functional Limitations
Endurance, Ambulation, Bowel/Bladder Incontinence

Activities Permitted
Cane, Transfer bed/Chair, Exercises Prescribed, Up As Tolerated

DME & Supplies	Safety Measures
sling, cane, diabetic supplies	transfer with assist, supervision at all times, sharps precautions, restricted ROM, hand rails, activity supervision, no bp left arm, bleeding precautions, standard precautions, diabetic precautions, fall precautions, medication safety, smoke detectors , emergency phone # clearly displayed, bathroom safety, ambulates with assistance, ambulates with device, NWB LUE
Nutrition	**Allergies**
diabetic,	sulfa drugs!latex

Advance Directives
No Advance Directive

Caregiver Status
2. Non-agency caregiver(s) need training/supportive services to provide assistance; 2. Non-agency caregiver(s) need training/supportive services to provide assistance

Rehabilitation Potential
SELF-CARE: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities., MOBILITY: 2. Needed Some Help - Patient needed partial assistance from another person to complete any activities.

DISCHARGE PLAN:
SN: family/caregiver will be responsible for managing treatment

PT and OT: patient will be responsible for managing treatment

Orders for Discipline and Treatment:
1 - SOC - SN

PT Eval

OT Eval

SN CAREPLAN

SN frequency WK1: 1 (09/15/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26)

PARAMETERS FOR PHYSICIAN NOTIFICATION: temperature < 95 > 100.5, heart rate < 50 > 110, respiratory rate < 8 > 22, blood pressure systolic < 90 > 169, blood pressure diastolic < 60 > 90, O2 saturation < 88 > 100, pain < 0 > 5

CAREGIVER: 2. Non-agency caregiver(s) need training/supportive services to provide assistance

HOSPITALIZATION RISKS: 1. History of falls (2 or more falls - or any fall with an injury - in the past 12 months), 7. Currently taking 5 or more medications

STANDING ORDERS: infection control: hygiene, proper hand washing; advance directive: plan if patient is unable to make healthcare decisions ; fall precautions: wear sensible shoes, remove home hazards, living space adequately lit, assistive devices prn; emergency preparedness: plan for prn evacuation, resumption of home health visits; Assess the patient's incision on post op day 7 and the nurse or physical therapist will remove aquacel dressing leaving OTA; if incision is draining educate pt/pcg on cleaning with normal saline and covering with dry gauze daily and as needed.
Assess/Instruct Pt/Pcg: Ice to ____ x 20 minutes each hour while awake. If cold machine ordered apply 20 minutes on and 20 minutes off for 3-4 times a day.
Assess/Instruct all body systems/vital signs/complications, Blood Pressure; systolic is greater than 169 mm Hg or less than 90 mm Hg; diastolic is greater than 100 mm Hg or less than 55 mm Hg, Clinician to assess comorbidities and report changes in condition to the patient's physician, Pain Rating is greater than 6 on 0-10 scale, Pulse is greater than 110 or less than 50, Respirations are greater than 22 or less than 8, SPO2: is less than 90 % at rest /with exertion, Temperature is greater than 100.5 F or less than 95.0 F, Pain Rating is greater than 6 on 0-10 scale
Implement Fall Prevention Program, Instruct and educate the patient/PCG on wearing compression stockings for the next 4 weeks per discharge instructions.
Instruct the pt/PCG on using the incentive spirometer 10 times every 2 hour while awake.
Provide education content at patient's level of health literacy.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury.
Assess: Musculoskeletal status.
Teach Pt/Pcg to maintain appropriate wt bearing status as ordered by MD, total joint replacement precautions as applicable, Safe stair climbing skills, Safe, effective use of adaptive/assist device
Assess/Instruct Pt/Pcg: Pain management measures; assess pain level, pain medication, rest, body alignment, ROM, meditation, massage.
Pt/Pcg educated in pain management techniques including positioning and relaxation techniques
Instruct Pt/Pcg: Medication actions, uses, frequency, dose, side effects, interactions of all new/change meds, Provide medication education,.
Assess/Instruct Pt/Pcg: Safety measures to prevent injury, Therapeutic Exercise, Transfer Training
Monitor surgical wound for s/s of infection, educate on s/s of concern and infection prevention to promote wound healing.

; Skin Preservation: Measures to prevent skin breakdown; pressure relief, incontinence care, nutrition, hydration ; Pain: Pain management measures; pain medication, rest, body alignment, ROM, meditation, massage ; Medications: Medication actions, uses, frequency, dose, interactions of all new/change meds
Advance Directive:No Advance Directive

09/16/2026 Problems : obesity (NU)
muscle weakness (MS)
A1250 - Lack of Necessary Transportation
M1610 - Urinary Incontinence
Pain Effect on Sleep
M1400 - Dyspnea

SN NARRATIVE

Home health skilled nursing admission completed for a 70-year-old female recently discharged from a skilled nursing facility. Past medical history includes type 2 diabetes mellitus requiring insulin, multiple fractures, atherosclerotic heart disease, right-sided hemiplegia secondary to CVA, GERD, hyperlipidemia, hypertension, edema, and non-Hodgkin lymphoma. Patient is alert and oriented 3, lives with her husband, and uses a cane for ambulation. Vital signs stable. Skin assessment completed with no skin issues noted. Medication reconciliation completed. Education provided on medication management, insulin administration, blood glucose monitoring, recognition and management of hypoglycemia and hyperglycemia, fall prevention, safe cane use, edema management, and skin integrity. Skilled nursing services are indicated for continued assessment, disease management, medication education, and prevention of complications following discharge.

SN GOALS

PATIENT-STATED GOAL: Patient stated she would like to remain free of fall and regain strength

GOALS
patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* depression-prevention strategies including avoidance of isolation
* healthy eating
* sleeping habits
* identification of activities that bring pleasure
* preventive care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* urinary incontinence management including bladder training
* Kegel exercises
* skin care
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms
* recalls related medication(s) purpose, schedule

patient self-administers medications as prescribed
* recalls related medication(s) purpose, schedule

patient's transportation needs are met

patient is adequately supervised

meal preparation is available to patient for all meals

caregiver administers and/or packages medications appropriately

caregiver performs medical/rehabilitation treatments with adequate competence

M2020 - Oral Med Management
swelling in legs/around eyes
abnormal blood pressure
weak hand grips
balance deficit
limited range of motion
limited endurance
limited strength
abnormal BS < 70/140 > mg/dL
B0200 - Hearing Deficit
meal preparation
M2102c - Med Admin
D0160 - Depression
M2102f - Patient Supervision
M2102d - Caregiver Performs Treatment

PROCEDURES: glucose testing via monitor, bladder training, teach/coordinate/arrange medication packaging and/or administration, coordinate/arrange for adequate patient supervision, coordinate/arrange preparation of missing meals

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, * depression-prevention strategies including avoidance of isolation healthy eating sleeping habits identification of activities that bring pleasure preventive care, related medication(s) purpose, schedule, * urinary incontinence management including bladder training Kegel exercises skin care, related medication(s) purpose, schedule, * how to keep home safe for hearing-impaired including installing special fire-detector/CO2 alarms, related medication(s) purpose, schedule, patient self-administers medications as prescribed, related medication(s) purpose, schedule, patient's transportation needs are met, patient is adequately supervised, meal preparation is available to patient for all meals, caregiver administers and/or packages medications appropriately, caregiver performs medical/rehabilitation treatments with adequate competence

OT CAREPLAN
OT frequency WK1: 1 (09/15/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK3: 1 (09/27/26-10/03/26),WK4: 1 (10/04/26-10/10/26),WK5: 1 (10/11/26-10/17/26),WK6: 1 (10/18/26-10/24/26),WK7: 1 (10/25/26-10/31/26),WK8: 1 (11/01/26-11/07/26)

09/18/2026 Problems : Pain Effect on Sleep
Pain Interference with Therapy activities
Pain Interference with ADLs
M1400 - Dyspnea
GG0130B1 - Oral Hygiene
GG0130C1 - Toileting Hygiene
GG0130E1 - Shower/Bathe Self
GG0130G1 - Lower Body Dressing
GG0130H1 - Don/Doff Footwear
GG0130A1 - Eating
GG0130F1 - Upper Body Dressing

PROCEDURES: Medication Review : Medication reviewed with patient with all medications in the home, home exercise program: Right UE triceps extensions, biceps curls shoulder raises 2-3 sets 8-12 reps. Left UE PROM in all planes, equipment training, work simplification/energy conservation, transfers training: Skilled OT, assist with bathing: Skilled OT, assist with lower body dressing: Skilled OT, assist with upper body dressing: Skilled OT

TEACH PATIENT/CAREGIVER: * lifestyle modifications to manage respiratory condition including diet changes and regular exercise strategies to control shortness of breath home remedies to keep lungs healthy, related medication(s) purpose, schedule, * how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain teach relaxation skills and diversional activities, related medication(s) purpose, schedule, Oral Hygiene - 06. Independent, Toileting Hygiene - 06. Independent, Shower/Bathe Self - 05. Setup or clean-up assistance, Lower Body Dressing - 06. Independent, Don/Doff Footwear - 06. Independent, Eating - 06. Independent, Upper Body Dressing - 06. Independent

OT NARRATIVE
70-year-old female presenting to skilled OT services s/p hospitalization secondary to recent fall in bathroom and sustained left displaced neck of humerus. Past medical history significant for type 2 diabetes mellitus requiring insulin, multiple fractures, atherosclerotic heart disease, right-sided hemiplegia secondary to CVA, GERD, hyperlipidemia, hypertension, edema, and non-Hodgkin lymphoma.

Patient previously resided in a multi level single family home with her husband. Patient completed basic self care, functional transfer and functional ambulation tasks independently. Patient currently presents with decreased standing balance, standing tolerance, bilateral UE strength and activity tolerance resulting in decreased self care, functional transfer and functional ambulation independence. Skilled OT services recommended at this time to address deficits hindering Patient from returning to prior level of functional independence.

OT GOALS
PATIENT-STATED GOAL: Get in the shower

GOALS
Shower/Bathe Self - 05. Setup or clean-up assistance

patient/caregiver recalls
* lifestyle modifications to manage respiratory condition including
* diet changes and regular exercise
* strategies to control shortness of breath
* home remedies to keep lungs healthy
* recalls related medication(s) purpose, schedule

patient/caregiver recalls
* how to maintain a diary to monitor effective and non-effective pain relief including documenting time of pain, rating, precipitating events, medications, treatments, and what works best to relieve pain
* teach relaxation skills and diversional activities
* recalls related medication(s) purpose, schedule

Oral Hygiene - 06. Independent

Toileting Hygiene - 06. Independent

Lower Body Dressing - 06. Independent

Don/Doff Footwear - 06. Independent

Eating - 06. Independent

	Upper Body Dressing - 06. Independent

PT CAREPLAN
PT frequency WK1: 1 (09/15/26-09/19/26),WK2: 1 (09/20/26-09/26/26),WK4: 1 (10/04/26-10/10/26),WK6: 1 (10/18/26-10/24/26),WK8: 1 (11/01/26-11/07/26)

09/18/2026 Problems : GG0170D1 - Sit to Stand
GG0170F1 - Toilet Transfer
GG0170G1 - Car Transfer
GG0170I1 - Walk 10 Feet
GG0170J1 - Walk 50 ft with 2 Turns
GG0170K1 - Walk 150 Feet
GG0170M1 - 1 - Step (curb)
GG0170N1 - 4 Steps
GG0170O1 - 12 Steps
GG0170P1 - Picking Up Object
GG0170L1 - Walk 10 ft on Uneven Surface
GG0170E1 - Chair to Bed to Chair

PROCEDURES: Dynamic and static standing activities : Side stepping, tandem gait, unilateral stance., home exercise program: Supine Hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction . Standing knee flexion, hip abduction, hip extension, plantarflexion, squats. Sitting knee extension, ankle pumps, gait training/stair training, transfers training

TEACH PATIENT/CAREGIVER: Sit to Stand - 06. Independent, Chair to Bed to Chair - 06. Independent, Toilet Transfer - 06. Independent, Car Transfer - 06. Independent, Walk 10 Feet - 04. Supervision or touching assistance, Walk 50 ft with 2 Turns - 04. Supervision or touching assistance, Walk 150 Feet - 04. Supervision or touching assistance, 1 - Step (curb) - 04. Supervision or touching assistance, 4 Steps - 04. Supervision or touching assistance, 12 Steps - 04. Supervision or touching assistance, Picking Up Object - 04. Supervision or touching assistance, Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

PT NARRATIVE
Client is a 70 year old with recent fall in bathroom and sustained left displaced neck of humerus. History includes DM, CVA with right HEMIPLEGIA 2/25, CAD, HTN, NONHODGKINS LYMPHOMA, HYPERLIPIDS, REFLUX, FALLS. Lives with husband in single family home with 6 steps and rail to enter. Bed and bath on first floor. Ambulates on indoor surface without device 30 feet with supervision and occasionally reaches for support. Transfers to bed, chair and toilet with supervision and cues not to put weight through left arm. Bed mobility is with supervision and cues not to weight bearing on left arm. Therapist did not assess outside skills, car transfer or steps. Client tolerated 10 reps of supine hip flexion, bridging, hooklying rotation, straight leg raise, hip abduction, knee extension, ankle pumps. Client is homebound due to significant effort to leave home with human assistance and as evidenced by tinetti score of 15/28. Client would benefit from home therapy to increase strength and return to independence. Client needs to see Dr Shiu, orthopedic physician re left shoulder fracture to determine if client can now weight bearing and advance activities.

PT GOALS
PATIENT-STATED GOAL: To be steady on my feet and have no additional falls

GOALS
Chair to Bed to Chair - 06. Independent

Toilet Transfer - 06. Independent

Car Transfer - 06. Independent

Walk 150 Feet - 04. Supervision or touching assistance

1 - Step (curb) - 04. Supervision or touching assistance

4 Steps - 04. Supervision or touching assistance

12 Steps - 04. Supervision or touching assistance

Walk 10 ft on Uneven Surface - 04. Supervision or touching assistance

Sit to Stand - 06. Independent

Walk 10 Feet - 04. Supervision or touching assistance

Walk 50 ft with 2 Turns - 04. Supervision or touching assistance

Picking Up Object - 04. Supervision or touching assistance

Signature and Date of Verbal SOC Where Applicable:
Electronically signed by: Charles Messick RN on 09/15/2026

I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. This patient is under my care, and I have authorized the services on this plan of care and I or another physician will periodically review this plan. I attest that a valid face-to-face encounter occurred (or will occur) within timeframe requirements and it is related to the primary reason the patient requires home health services.
F2F date: 09/04/2026

Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Certifying Physician or Allowed Practitioner Name and Address **Ayman Akkad**
7800 Osler Dr
Towson, MD 21204
NPI 1639126113

Phone Number 4108325525

Fax Number 14103859393

Physician's Signature and Date Signed

X

Ayman Akkad, MD
09/04/2026: Date of physician last face-to-face